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DDASaccident259

Humanitarian Demining Accident and Incident Database
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DDAS Accident Report

Accident details

Report date:	18/05/2006	**Accident number:**	259
Accident time:	not recorded	**Accident Date:**	04/06/1999
Where it occurred:	Plowshare minefield, Cordon Sanitaire	**Country:**	Zimbabwe
Primary cause:	Unavoidable (?)	**Secondary cause:**	Inadequate equipment (?)
Class:	Excavation accident	**Date of main report:**	[No date recorded]
ID original source:	none	**Name of source:**	KMS
Organisation:	Name removed		
Mine/device:	R2M2 AP blast	**Ground condition:**	wet woodland (bush)
Date record created:	18/02/2004	**Date last modified:**	18/02/2004
No of victims:	1	**No of documents:**	1

Map details

Longitude:		**Latitude:**	
Alt. coord. system:		**Coordinates fixed by:**	
Map east:		**Map north:**	
Map scale:	not recorded	**Map series:**	
Map edition:		**Map sheet:**	
Map name:			

Accident Notes

no independent investigation available (?)

handtool may have increased injury (?)

squatting/kneeling to excavate (?)

inadequate investigation (?)

Accident report

At the time of this accident the demining company operated in two-man teams using a one-man drill. One deminer looked for tripwires, cut undergrowth, used the detector and excavated finds while the other watched from a safe distance and "controlled" him. The group issued frontal protection and their drills assumed that the deminer would kneel or squat while excavating.

An internal Accident report was made available by the demining group in December 1999. The following summarises its content.

The victim was engaged in carrying out a "missing mine drill" at the time of the accident. This was used when there was a break in the pattern of discovered mines, so the breach was examined again. While the victim was "excavating" a detector signal the "suspected R2M2" mine "functioned". The victim sustained "a slight cut and some bruising to his left hand".

The victim was treated "on the spot" by the medic and then taken to the field medical unit. The site was closed and the remaining mines destroyed.

A site investigation showed that the victim's detector was "on and functioning". His water carrier was about five metres away in the cleared lane. His prodder was on site and undamaged. His visor was 80cms away with the head-frame broken.

Conclusion

The investigators concluded that the victim was working correctly and was excavating a detector reading. They found that his visor and apron were "covered with mud" and his deformed trowel was found lying about a metre from the detonation. The soil around the hole was still wet, showing that the victim has used enough water to soften the ground. Beneath the point of detonation was "a deep burrow, probably dug by mice". "Detonation signs" were only visible on one side of the "blast hole".

They added that the victim could see the mine before it detonated and the damage to the trowel shows that he hit it with the tip of the trowel. They believed that he was "scraping horizontally" so felt that the "accident seems to be caused by a mine that was tilted".

They added that the victim "was protected from serious injury due to the fact that he was wearing protective clothing correctly".

Victim Report

Victim number:	333	**Name:**	**Name removed**
Age:		**Gender:**	Male
Status:	deminer	**Fit for work:**	yes
Compensation:	not made available	**Time to hospital:**	not applicable
Protection issued:	Frontal apron Long visor	**Protection used:**	Frontal apron, Long visor

Summary of injuries:

INJURIES

minor Hand

COMMENT

No medical report was made available. The victim was not taken to hospital because his injuries were too minor.

Analysis

The primary cause of this accident is listed as *"Unavoidable"* because the victim appears to have been working properly in accordance with his SOPs when the accident occurred. The

damage to his hand was almost certainly a consequence of using a short excavating tool. The secondary cause is listed as *“Inadequate equipment”*.

The accident report covering this event bears a striking similarity to others made around the same time by this group. Clearly one report was simply edited to make the next. This is an undesirable way of making reports because there is a tendency to repeat details that may actually have differed.